STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	006245	A. BUILDING: _____ B. WING _____	03/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION HOSPITAL OF FORT WAYNE GENEI	7970 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: Nancy Otten, RN, PHNS Surveyor 33212 Facility #: 006245 Type of Survey: State Licensure Off Site JCAHO Accreditation Survey. Date of On-site survey- Hospital full survey 3/12-14/2013 Date of off-site review: 9/4/2013 Based on review of the 3/12-14/2013 JCAHO Accreditation Survey Report, it has been determined that Rehabilitation Hospital of Ft. Wayne meets the requirements for Hospital Licensure in Indiana for 2013.	S 000		